Supreme Court, U.S.
FILED

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~~(No. 97-5909)~~

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM 1998

LINDA ALLINDER,
Petitioner,

v.

INTER-CITY PRODUCTS CORPORATION (USA), and
ROBERT HENNINGSEN,
Respondents,

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether there is federal subject matter jurisdiction in this case where this case was removed to federal court pursuant to 28 U.S.C. §1331 because there was alleged to have been a federal question pursuant to the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §1101 et seq., but where neither the district court or Court of Appeals below asked whether a plan existed or asked whether fiduciary status existed, and no proof was produced to establish those facts and, therefore, would qualify this case for federal jurisdiction.

2. In the alternative, whether the Court of Appeals below applied the wrong standard in granting relief to the respondents when it predicated its holding on the fact that the respondents were fiduciaries to the ERISA plan, but applied the standard announced in *Mertens v. Hewitt Assoc.*, 508 U.S. 248 (1993), in which the holding there was predicated on the question whether ERISA authorizes suites money damages against *nonfiduciaries* to an ERISA plan.

3. In the alternative, whether the Court of Appeals should have applied the standard announced in *Varity Corp. v. Howe*, 116 S.Ct. 1065 (1996), which allows an individual to obtain equitable relief against a fiduciary to an ERISA plan, where the Court of Appeals predicated its holding on the fact that the respondents were fiduciaries to the ERISA plan.

PARTIES TO THE PROCEEDING

In addition to the petitioner, Linda Allinder, who appeared as Plaintiff-Appellant in the Sixth Circuit proceeding with her Attorney of Record, James L. Harris, and Brian O. Bowhan, attorney at law, joined the petitioner in her cause as co-counsel in the Petition for a Rehearing at the Court of Appeals and is also Attorney of Record; and respondents, Inter-City Products Corporation and Robert Henningsen, appeared as Defendants-Appellees before the Sixth Circuit.

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1. This case is rooted entirely in state law and there is no federal subject matter jurisdiction under 28 U.S.C. §1331 as ERISA does not apply here because there is no employee benefit plan, but only an insurance policy purchased by the respondents.

2. In the alternative, the Court of Appeals decided this case on the assumption that the respondents were fiduciaries to an ERISA plan, but the court predicated its decision pursuant to the this Court's holding in *Mertens v. Hewitt Assoc.*, 508 U.S. 248 (1993), but the only issue in *Mertens* was

whether a beneficiary could bring an action for money damages against a non-fiduciary, but the questions of fact and law rooted in the *Mertens* decision do not apply here because the respondents here would have had to have been fiduciaries and, therefore, subject to an action for money damages.

3. **Alternatively, if ERISA applies, the Court of Appeals erred in denying appropriate equitable relief.**

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The order of the United States Court of Appeals for the Sixth Circuit affirming the order by the United States District Court is reproduced in the petitioner's appendix at A1. The order of the United States Court of Appeals for the Sixth Circuit denying the petitioner's petition for rehearing is reproduced in petitioner's appendix at A20.

JURISDICTION

The order of court of appeals was entered on August 10, 1998. (A1). Petitioner filed a timely petition for rehearing which was denied by the court of appeals on August 31, 1998.
This Court has jurisdiction under 28 U.S.C. §1254(1).

STATEMENT OF THE CASE

Procedural history.

This petition arises out of a removal to federal court of a case originally filed in state court pursuant to 28 U.S.C. §1311. The reason for the removal was the assertion that this case was governed by ERISA (29 U.S.C. §1101 et seq.) and was, therefore, preempted. That case was dismissed without prejudice. This case was subsequently filed in federal court where summary judgment was entered against the petitioner. The court of appeals affirmed and denied the petition for a rehearing. This Petition for a Writ of Certiorari followed.

The facts.

The case arose when the petitioner, an employee of the

respondents', became disabled because she was exposed to a pesticide in her work area at the respondents' facility. Because the exposure to the pesticide disabled the petitioner to the extent that she could no longer work, she was involuntarily terminated from employment in August 1990.

Because the Respondent Inter-City Products Corporation (USA) (hereafter, Company), had purchased a long term disability policy, the petitioner attempted to file a claim for long term disability benefits under the policy. When she requested, at first verbally, then in a letter from her attorney, that her employer fill out its portion of the disability claim form, the Company refused to do so.

The petitioner then wrote a letter to the Vice President of Human Resources for the Company, Respondent Robert Henningsen, asking him to reconsider. He refused to reconsider stating that the petitioner was not an employee at the time of her claim. The Company conceded during oral argument at the Court of Appeals that their representation that the petitioner had to be an active employee at the time she made a claim for disability insurance benefits was false.

The petitioner then hired an attorney who negotiated a "side agreement" with the insurance company who sold the policy to the Company. As a result of the negotiations, the petitioner filled out the Company portion of the claim form and submitted the completed form directly to the insurance company. The insurance company then paid the petitioner her benefits to which she was entitled under the policy in a lump-sum payment. The lump sum did not include interest. The terms of the insurance policy were violated by this tardy lump sum payment because the payments were to be made monthly.

Because of the treatment she had received at the hands of the respondents, the petitioner filed suit in state court stating claims for conversion, tortuous interference with contractual rights, and misrepresentation. The respondents then removed the case to federal district court pursuant to 28

U.S.C. §1331 where the case was dismissed without prejudice because all of the petitioner's theories were rooted in state law.

Under the civil enforcement provisions of 29 U.S.C. § 1132 (a)(3) and §1132(c), the petitioner refiled her case in federal district court alleging that the Company violated ERISA when it refused to complete its portion of the claim form under §1132(c) and for a breach of fiduciary duty §1104(a)(1) and§1106(b)(2).

At no time during any of the proceedings in any of the two cases, that is neither in the first case which was removed to federal court and then dismissed without prejudice nor in the second case which is before this Court now, did the respondents produce a plan which would qualify the long term disability policy to be a plan under ERISA. Further, neither the district court nor the Court of Appeals inquired whether there was a plan or made a finding that a plan existed under ERISA. It follows that neither court inquired whether the respondents were fiduciaries or even if the petitioner was, in fact, a beneficiary under a plan.

REASONS FOR GRANTING THE WRIT

1. **This case is rooted entirely in state law and there is no federal subject matter jurisdiction under 28 U.S.C. §1331 as ERISA does not apply here because there is no employee benefit plan, but only an insurance policy purchased by the respondents.**

The petitioner raises the issue of subject matter jurisdiction because this case was filed in federal court after

the federal district court dismissed the original action without prejudice. That original action was previously filed in state court, but was removed to federal district court by the respondents pursuant to 28 U.S.C. §1331 citing that a federal question was involved and, that pursuant to ERISA, the action was preempted. After the federal district court dismissed that action without prejudice because only theories under state law were pled, the petitioner, relying on the respondents' ERISA theory and the subsequent concurrence of the district court, filed this case in federal district court citing a claim under the enforcement provisions of ERISA.

After careful review of the respondents' theories, e.g., that this cause is pre-empted by ERISA, the petitioner now concludes that ERISA does not apply and there is no federal preemption or even subject matter jurisdiction. What is really involved is that the company purchased an insurance policy only and did not establish an employee plan within the scope of ERISA. Although insurance policies only are not covered by ERISA, the appellant has not raised the issue of subject matter jurisdiction until her Petition for a Rehearing was before the Court of Appeals.

The issue of whether subject matter jurisdiction exists can be raised at any time, either at the trial level or appellate level. *Clark v. Paul Gray, Inc.*, 306 U.S. 583, 59 S.Ct. 744, 83 L.Ed. 1001 (1939), see, *Beck v. Miriani,* 293 F.2d 333 (6th Cir. 1961). Since this issue goes to the inherent power of the federal courts to entertain the case, the parties may not agree or consent to create jurisdiction. *Nierbo Co. V. Bethlehem Shipbuilding Corp.*, 308 U.S. 165, 60 S.Ct. 153, 84 L.Ed. 167 (1939). Further, the failure to raise the issue of subject matter jurisdiction at an earlier stage of the proceeding cannot be deemed to be a waiver as the issue of subject-matter jurisdiction cannot be waived. *Alliance of America Insurers v. Cuomo,* 854 F.2d 591 (2nd Cir. 1988). It follows that even if a plaintiff pleads a theory under federal law in response an

affirmative defense, and if both parties mistakenly litigate under a federal theory that really does not exist, which is what happened here, that mutual mistake cannot convey subject matter jurisdiction where none exists.

Indeed, the entire strategy used by the petitioner when she allowed the dismissal to go down in the original action without an appeal was one of acquiescence to the court's holding and the respondents theory that ERISA did apply to her case and she, therefore, believed that the appropriate forum for her claim was in federal court. When the petitioner subsequently re-filed her cause in federal district court on the theory that she could recover money damages from the respondents because of an ERISA violation, she was unable to produce a plan. Rather, she consistently referred to the long term disability insurance policy identified above.

The petitioner now realizes that she needs to prosecute her claim in state court because her cause of action is only rooted in state law. Although she now believes the summary judgment entered against her is void because the federal courts do not have jurisdiction, she may not be able to re-open or re-file there for two reasons.

First, as long as summary judgment which has been entered against her in federal district court stands, she will probably not persuade the state court that the summary judgment in federal court is without effect as to her claim. Therefore, the petitioner is faced with the practical result that her claim may by barred by *res judicata* or *collateral estoppel*. Thus, this entire jurisdictional question of whether ERISA applies must be made here in federal court because as long as the federal preemption issues remain decided in federal court, the petitioner opens herself to sanctions if she reopens her case in the state court.

Second, if the petitioner desires to re-file in state court, the applicable statute of limitations in the state where she originally filed, Tennessee, may have run and her only

hope is to re-open the original case.

The burden of proof on subject-matter jurisdiction rests with the party asserting it. *Adams v. Bain,* 697 F.2d 1213 (4th Cir. 1982). The respondents originally asserted federal jurisdiction. That the petitioner now challenges federal jurisdiction does not shift the burden from the respondents to the petitioner. The respondent must come forward with competent proof of jurisdiction. *Grafton Corp. v. Hausermann,* 602 F.2d 781 (7th Cir. 1979). The respondents have not cited any facts, including those recited in their original notice to have the case removed to federal court, which show that the policy at issue qualifies as an ERISA plan.

As discussed above, the first time that the petitioner has raised this subject matter jurisdiction issue was in her Petition for a Rehearing in the Court of Appeals, but, for the reasons stated above, the failure to do so cannot prejudice her in any way. The petitioner asserts that the long term disability policy, which is claimed by the respondents to be an ERISA plan, is nothing more than an insurance policy. That policy cannot pass the litmus test which would qualify it as an ERISA plan.

All the respondents' Notice of Removal, which was filed in state court, stated was that removal of the case to federal court was necessary because ERISA preempted all of the state law claims. Their assertion that there was a plan was conclusory with no verification that there was a plan which satisfied standard of the statute. The federal trial court's Order and Memorandum, which dismissed the original case on the pleadings, contained no finding that a valid ERISA plan existed, or that the respondents were fiduciaries under the plan, and the issue has never been argued or briefed by either party. Essentially, this entire matter has proceeded in federal court by implied consent of the parties and the courts.

In order to show that a plan exists which will meet

certain minimum standards under ERISA, the respondents must demonstrate (1) they are employers engaged in commerce (29 U.S.C. § 1003(a)), (2) that there must be a plan for the purpose of providing certain benefits (29 U.S.C. §1002(1)), (3) there must be a written instrument providing for fiduciaries, and (4) that the assets of the plan must be held in trust by trustees to manage and control the assets of the plan (29 U.S.C. §§1102, 1103).

With the foregoing standard in mind, a federal district court found that an employer plan could not qualify as an ERISA plan in the absence of an affirmative showing that the above identified minimum criteria had been met. *National Metalcrafters, A Division of Keystone v. McNeil*, 602 F. Supp. 232, 235-6 (N.D. Ill. 1985), rev'd. on other grounds, 784 F.2d 817 (7th Cir. 198_). There the court noted that the employer failed to show that there was an established fund, there were no named beneficiaries, or fiduciaries. Further, there was "no evidence of a summary plan description, no annual reports, no trust agreement, which would lead the court to conclude that (the plan) was an ERISA fund...." *Id.*

Here, it appears from the facts, as recited by the Court of Appeals in its opinion at page A6, that the court recognized that the petitioner's attorney negotiated a "side agreement with the insurance company." That statement alone should have raised two red flags. The first red flag should have been on the face of the statement that the court recognized there was a side agreement. There is virtually no way in which a plan can act without the trustee or fiduciary. 29 U.S.C. §1102. Therefore, it would have been impossible to negotiate a "side agreement."

The second red flag raised should have been that there was an insurance company involved in the side agreement. Under the ERISA scheme, insurance companies cannot be a benefit plan or a trust established under the plan, unless the plan's primary purpose is to provide death benefits. 29

U.S.C. §1144 (b)(2)(A). The insurance policy in this case is a long term disability policy. The reason for that rule is probably that there would necessarily be a commingling of funds with other assets of the insurance company to the extent that the plan assets would lose their identity.

Again, in order to qualify as a plan, there must be a corpus which is held in trust by trustees who manage and control the plan. Those trustees are the fiduciaries. All of the participants must be identified in the plan. Those elements are patently missing here. There is a vast distinction between an employer buying an insurance policy and an employer establishing an ERISA plan, and the purchase of insurance alone does not prove that a plan has been established. In this case, there was never a query made as to the existence of an ERISA plan after the insurance policy had been identified.

But, ERISA does not regulate the bare purchase of insurance if the employer who purchases the insurance neither directly nor indirectly owns controls, administers, or assumes responsibility for the policy or its benefits. *Taggart Corp. v. Life &Health Benefits Administration,* 617 F.2d 1208 (5th Cir. 1980). In other words, if a plan looks like an insurance policy and not a plan, then it is an insurance policy and not a plan. Here, the facts and circumstances observed by the district court and the Court of Appeals do not predispose one to conclude that an ERISA plan exists. Rather, one is predisposed to conclude that what is involved here is an insurance policy and not an ERISA plan.

Again, the Court of Appeals recognized in its opinion at page A6 that the petitioner negotiated with the insurance company a "side deal" where she filled in the respondent's (employer's) portion of the claim form and then submitted the completed form to the insurance company, which then processed the petitioner's claim and paid her.

But, if there was a plan with a fiduciary, the question which both the district court and the Court of Appeals below

did not address was this: how was it that money was paid to the petitioner by the insurance company without authorization from a fiduciary? The next question should have been; how is it that there was a company portion of an insurance claim form to be filled out which could be circumvented? The answer to both questions is that under an ERISA plan, only the trustee can administer the plan and the side deal would not have been possible because an ERISA plan cannot be circumvented by a third party.

This court in *Lockheed Corp. et al., v. Spink*, 517 U.S. 882, 116 S.Ct. 1763 (1996) stated that it was error for the Court of Appeals not to ask whether fiduciary status existed before it found violations of a fiduciary's duty. It follows, therefore, that the parties involved in ERISA litigation must first establish the facts that a plan exists by establishing the plan instrument, and who the fiduciaries and beneficiaries are. In other words, it appears from the court's admonition in *Lockheed Corp., Id.*, that it is the duty of the court to insure that the parties make a *prima facia* showing of the existence of a plan and it may be reversible error not to do that. The required *prima facia* showing was not made in this case and the petitioner does not believe that it can be made because there is no ERISA plan.

The failure of those courts to require that the parties establish that there was a plan and to establish who the fiduciary was plain error. The result of that error is that the petitioner, as a practical matter, is bound by a judgment which is invalid because the federal courts have no subject matter jurisdiction over her claim.

The only privity in a valid ERISA plan is between fiduciary and beneficiary; not between employer and employee. The lines of demarcation are clear cut and not readily capable of dilution or circumvention. 29 U.S.C. §§1002, 1102, 1103.

The overriding fact here is that the insurance

company, who could not be a fiduciary, acted entirely on its own when it authorized the "side deal" and rightly paid the money to the petitioner without the authorization of the respondents. Indeed, there has been no showing that the respondents had any control over the insurance policy. It is inconceivable for that to happen under an ERISA plan. In other words, the only one who could make the check would be the trustee, who could not have been an insurance company.

Finally, as shown above, ERISA plans must designate a fiduciary. Throughout this entire case no one has identified who the players are. There has been no showing of who the fiduciary is or how the plan is identified. Also, the tort and breach of contract claims asserted in the original complaint were against the respondents and not against an ERISA plan. In any event, as they have not claimed fiduciary status, the state actions against the respondents cannot be preempted. *Simmons v. Prudential Ins. Co.*, 641 F. Supp 675 (D.C. Colo. 1986); *Lessard v. Metropolitan Life Ins. Co.*, 618 F. Supp 1268 (D.C. Me. 1985). The petitioner does not believe that the respondents can claim fiduciary status or any other special protection under ERISA because they did act in any role under ERISA.

It is absolutely imperative that the Writ be granted in order that the Court can dismiss this case or remand it to the district court in order that the most fundamental factual determinations be made in order to determine whether an ERISA plan exists. Courts cannot just create jurisdictions for themselves and they cannot retain jurisdiction where none exists.

2. **In the alternative, the Court of Appeals decided this case on the assumption that the respondents were fiduciaries to an ERISA plan, but the court predicated its decision pursuant to the this Court's holding in *Mertens v. Hewitt Assoc.*, 508 U.S. 248 (1993), but the only issue in *Mertens* was whether a beneficiary could bring an action for money damages against a non-fiduciary, but the questions of fact and law rooted in the *Mertens* decision do not apply here because the respondents here would have had to have been fiduciaries and, therefore, subject to an action for money damages.**

Assuming, *arguendo*, that there was a plan, there has never been a finding, either by the trial court or by the Court of Appeals in what capacity under the ERISA plan the respondents acted. Indeed, the respondents have never asserted whether they either did or did not act as a fiduciary. The petitioner may have earlier alleged that but, as discussed above, those assertions were probably misplaced as she had no proof of the allegation and there has never been any proof by way of the plan instrument that the respondents were fiduciaries. The allegation that the respondents are fiduciaries was not part of the original allegations made in state court. Indeed, it appears they were made more by implication and only in response to the respondents' maneuver to remove this case to federal court. That point is important to reemphasize because without a finding of the proper role of the respondents, proper relief, if any, cannot be rendered.

At page A16 of the Court of Appeal's opinion, the court seemed to base its holding on *Mertens v. Hewitt Assoc.*,

508 U.S. 248,113 S. Ct. 2063, 124 L.Ed 2d 161 (1993) which addressed only whether a suit for money damages could be brought against a non-fiduciary to a plan. The Court of Appeals' holding was clearly predicated on the assumption that the respondents were fiduciaries to a plan. The Court of Appeals recited again and again what the appropriate relief was against a fiduciary. The Court of Appeals, with a view toward its misreading of *Mertens,* took one more step and stated that there was "nothing in the legislative history... to insure that plan *fiduciaries* faithfully execute their ministerial function of completing claim form for individual plan participants." Opinion at page A11. (Emphasis added). That statement was a complete misstatement of this Court's policy. The Court of Appeals cited no authority for its shocking proposition that a fiduciary to an ERISA plan could intentionally withhold claim forms from a plan beneficiary and, thereby, deprive said beneficiary of express benefits.

Again, the sole question in *Mertens* was "whether ERISA authorizes suits for money damages against *nonfiduciaries* who knowingly participate in a fiduciary's breach of fiduciary duty." *Id.* at 251. (Emphasis added). There the court was faced with petitioners who tried to shoehorn a malpractice case against an actuary, with whom they apparently had no privity, into a cause of action under ERISA. The court did not buy the theory and denied relief. On the other hand, here the implied theories were predicated on a fiduciary's breach of duty.

Further the Supreme Court's holding in *Varity Corp. v. Howe*, ___ U.S. ___, 116 S.Ct. 1065 (1996), which applies to a suit by a petitioner against a fiduciary, which is the theory asserted by the petitioner here, does not close the door on money damages for the petitioner. In *Varity,* the court began "with the question of Varity's fiduciary status." *Id.*, at 1071. It then made a finding that Varity was a fiduciary. *Id.* Then the court held that individual relief against a plan was

authorized under ERISA. *Id.*, at 1079. Essentially the court held that an individual can obtain equitable relief. *Id.* Here, among other relief, the petitioner is going to seek equitable relief in the form of restitution.

With a view towards the court's decision in *Varity,* which is a fiduciary case and the Court of Appeal's decision which was predicated on this Court's holding in *Mertens,* which is a non-fiduciary case, the conclusion is clear that the Court of Appeal's reliance upon the holding in *Mertens,* without a finding somewhere in the history of the case that the respondents are nonfiduciaries, is clearly misplaced. That is especially true here where the entire basis of the Court of Appeal's holding seems to be rooted in the assumption that the respondents are fiduciaries.

3. In the alternative that this court decides 1.) The insurance policy is an ERISA plan, and 2.) The respondents were fiduciaries, the Court of Appeals erred by deciding that the petitioner was not entitled to some form of equitable relief.

As the Supreme Court states in *Mertens*, p. 2068, 'a remedy traditionally viewed as "equitable" [is] an injunction or restitution.' The petitioner asked the courts to provide her with "appropriate equitable relief", as provided for by S1132(a)(3).

The petitioner had to pay her representative approximately one-fifth of her lump sum disability payment in order to obtain it. The respondents should make restitution of that amount with interest. Her attorney obtained the funds by an administrative agreement with the disability insurance company and not by legal means. The petitioner would like to ask the court to make her, as a victim, "whole for a breach of trust." *Id, 2074.*

Additionally, as the petitioner previously argued, she

is entitled to interest because interest is not and should not be considered extra-contractual damages. Appellant's policy stated that she was to receive benefits when due, not in a lump sum five years later. The petitioner contends that interest is a form of allowable restitution since running back the clock and instructing that payments be made to her monthly would be an impossible form of restitution.

The petitioner, at one point, conceded that ERISA did not provide for compensatory, punitive, or extra contractual damages. She conceded this only because the District Court in their Opinion stated that ERISA did not provide them. Subsequently, she has learned that the District's Courts stance on this point is incorrect. She believes that it would be unfair to hold her to this concession in light of these facts.

As *Varity* states on page 1078, ' The statute [ERISA] itself says that it seeks " to protect . . . the interest of participants . . . and beneficiaries . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries . . . and . . . providing for appropriate remedies . . . and ready access to the Federal courts." ERISA § 29(b). Section 404(a), in furtherance of this general objective, requires fiduciaries to discharge their duties "solely in the interest of the participants and beneficiaries." Given the objectives, it is hard to imagine why Congress would want to immunize breaches of fiduciary obligation that harm individuals by denying injured beneficiaries a remedy.'

To allow fiduciaries to act in a flagrantly harmful manner toward beneficiaries with absolute impunity only encourages fiduciaries to do so. The Supreme Court states in *Mertens*, p. 2068, ' . . . we have never interpreted the precise phrase "other appropriate equitable relief." This case offers the Supreme Court an opportunity to do so because it offers the appropriate factual situation and theories. It is this petitioner's contention that this honorable Court can pave the way for a proper interpretation of the aforementioned sections

of ERISA.

CONCLUSION

For the reasons stated above, the Court should grant the Writ of Certiorari.

Respectfully submitted,

/S/ _____

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Date: November 5, 1998

RECOMMENDED FOR FULL-TEXT PUBLICATION
Pursuant to Sixth Circuit Rule 24

ELECTRONIC CITATION: 1998 FED App. 0245P (6th Cir.)
File Name: 98a0245p.06

UNITED STATES COURT OF APPEALS

FOR THE SIXTH CIRCUIT

LINDA ALLINDER,
Plaintiff-Appellant,

v.

INTER-CITY PRODUCTS CORPORATION (USA), ROBERT HENNINGSEN,
Defendants-Appellees.

No. 97-5909

Appeal from the United States District Court
for the Middle District of Tennessee at Nashville.
No. 96-00834--John T. Nixon, Chief District Judge.

Argued: June 18, 1998

Decided and Filed: August 10, 1998

Before: MOORE, CLAY, and GILMAN, Circuit Judges.

COUNSEL

ARGUED: James L. Harris, Nashville, Tennessee, for Appellant. Bynum E. Tudor, III, FLOYD & TUDOR, Nashville, Tennessee, for Appellee. **ON BRIEF:** James L.

Harris, Nashville, Tennessee, for Appellant. Bynum E. Tudor, III, FLOYD & TUDOR, Nashville, Tennessee, for Appellee.

OPINION

RONALD LEE GILMAN, Circuit Judge. Linda Allinder sued her former employer, Inter-City Products Corporation, and its Vice President of Human Resources, Robert Henningsen (collectively "ICP"), for alleged violations of the Employee Retirement Income Security Act of 1974 ("ERISA"). She specifically claimed that ICP violated 29 U.S.C. § 1132(c) (refusal to supply requested information) and §§ 1104(a)(1) and 1106(b)(2) (breach of fiduciary duty). The essence of Allinder's suit concerned ICP's refusal to complete a form necessary for her to file a long-term disability insurance claim after she suffered a debilitating toxic reaction to pesticides sprayed in her work area. Although she was eventually paid in full the amount of benefits due under the policy, Allinder sought compensatory and punitive damages based on the allegedly intentional misrepresentations made by ICP in order to delay such payment.

While sympathetic to Allinder's plight, the district court nonetheless granted summary judgment in favor of ICP. The court's reasoning was twofold. First, the court concluded that ERISA's document-disclosure provisions do not cover claim forms. Second, relying upon this court's decision in *Tassinare v. American Nat. Ins. Co.*, 32 F.3d 220 (6th Cir. 1994), the district court held that Allinder could not make out a claim for breach of fiduciary duty because "fiduciary liability under ERISA arises in favor of the plan itself, and . . . plan participants may not seek to recover in an individual capacity." For the reasons set forth below, we **AFFIRM** the judgment of the district court.

I. BACKGROUND

A. ICP's Long-Term Disability Insurance Policy

Allinder began work as a computer systems analyst at ICP's Lovergne, Tennessee facility in May of 1986. As is standard in the employment setting, ICP offered its employees a package of benefits, including a company-sponsored long-term disability insurance policy ("the policy"). Allinder elected to enroll in the policy when she assumed her position at ICP. The terms and conditions of the policy were contained in an insurance contract signed by ICP and Life Insurance Company of North America ("insurance company").

Under the terms of the policy, an eligible employee was considered insured at the conclusion of an initial twelve-month waiting period. In order to fall within the class of eligible employees, the employee had to be in active service and regularly work a minimum of thirty hours a week. An employee was considered to be in active service if he or she performed "all of the regular duties of his work" during scheduled work days. The policy did provide one exception: employees did not have to meet the eligibility requirements if they were unable to work due to a "total disability."

The term "total disability" was defined by the policy as one where, "because of injury or sickness, [an employee] is unable to perform all the essential duties of his occupation." The policy further provided that insured employees were entitled to receive payment of long-term disability benefits after they had suffered from a "total disability" for more than six months. According to the section of the policy titled "Long Term Disability Benefits," the insurance company was obligated to make monthly payments of disability benefits once it received proof that "the employee became Totally Disabled *while insured*." (emphasis added). Insured employees were thus entitled to disability benefits once they became disabled, regardless of when they filed a claim for benefits. The policy concluded by stating that the insurance

company would deal solely with ICP, which was deemed the representative for the employee, and that any action ICP took in regard to the administration of the plan was binding on the employee.

B. The Disability Claim

ICP hired a local pest-control company in March of 1990 to spray for termites in the work area used by Allinder. Shortly after the spraying, Allinder began to experience a number of adverse symptoms, including itching, severe shortness of breath, extreme fatigue, pain, fever, and difficulty walking. After reporting these symptoms to her supervisor, Allinder left work and remained at home for several days. When she returned to work, Allinder requested that she be moved to another area in the building that had not been sprayed with pesticides. ICP accommodated Allinder's request and moved her to an alternate work area in its facility. Allinder's symptoms apparently subsided once she was transferred to the new work area. On April 10, 1990, however, Allinder's immediate supervisor, Rick Zorn, ordered Allinder to return to her original work area. Her symptoms reappeared upon her return. Allinder again requested and was allowed to go back to the alternate work area to carry out her job duties.

In early June of 1990, Zorn again forced Allinder to return to her original work area. Upon her return, Allinder began to suffer even more severe symptoms than she had earlier experienced. On June 19, 1990, Allinder's condition worsened to the point that she experienced uncontrollable tremors in her hands and legs, including one episode where her legs involuntarily jerked for four hours. Allinder was rushed to nearby Baptist Hospital's emergency room, where she was diagnosed as suffering from a toxic reaction to the pesticide sprayed by the pest-control company. Allinder's treating physician later diagnosed her as having suffered nerve damage from her exposure to the pesticide. Allinder remained away from work for the remainder of June because of her illness.

Allinder met with members of ICP's management in July to discuss her medical condition. At this meeting, Allinder presented a letter from her physician stating that she should not work in an area where pesticides have been applied or, alternatively, that she should be allowed to work at home. At the conclusion of this meeting, Allinder was asked whether she was resigning her job. Allinder responded that she intended to continue to work for ICP after she recovered from her illness. ICP nonetheless terminated Allinder's employment on August 24, 1990 due to her failure to report to work while she was seeking treatment for her illness. At the time she was fired, Allinder was less than a month away from being entitled to receive payment of long-term disability benefits.

On November 14, 1991, Allinder requested that ICP fill out its portion of the long-term disability claim form and submit it to the insurance company so that she could begin receiving payments of disability benefits. This claim form is a two-sided document. The front of the document provides questions for the employee to answer, while the back is to be completed by ICP. In a letter dated January 17, 1992, ICP's in-house counsel informed Allinder that the company would not fill out its portion of the form because she failed to "me[e]t the threshold requirement of active employee status at the time she made a claim for LTD (Long Term Disability) benefits."

This representation, as conceded by ICP at oral argument, was incorrect. According to the policy, the relevant date for determining whether insured employees were entitled to disability benefits was when they first became disabled, not when they made a claim for benefits. Because Allinder was insured at the time she first became disabled, she was entitled to disability benefits. The letter continued by informing Allinder that "the determination of active employee status is within the exclusive province of the Company. Thus, the submission of a LTD application form and setting in motion the decision-making process as to the merits of her claim is

inappropriate." Allinder believed ICP's statements and decided not to pursue her request any further at that time.

Prompted by information she later learned while attending a public health law course, Allinder reconsidered her earlier decision and submitted another request to ICP to fill out its portion of the long-term disability claim form. This request was dated December 30, 1993. ICP again denied Allinder's request for the same reasons it had given earlier. Allinder then contacted the insurance company to seek its aid in resolving the matter. In a letter dated January 20, 1994, an insurance-company representative responded to Allinder's request by noting that "in order to file a claim for Long Term Disability benefits, we require that you provide proof of loss by submitting the appropriate form, *i.e.*, . . . the Group Long Term Disability form to be completed by both you and your employer."

Allinder then retained the services of an attorney. In a letter dated March 27, 1995, Allinder's attorney requested that ICP provide copies of the portions of the insurance policy which indicated that Allinder was not entitled to long-term disability benefits. The defendant Henningsen responded by sending Allinder a copy of the section of the insurance policy titled "Eligibility for Employee Insurance." This section of the policy, however, only delineates the requirements for disability-insurance coverage. It does not address under what conditions benefits are payable.

Faced with ICP's recalcitrance, Allinder's attorney negotiated a side agreement with the insurance company. According to the agreement, Allinder would fill out ICP's portion of the claim form and submit the "completed" form to the insurance company to process her claim. After Allinder actually submitted the "completed" form, the insurance company in November of 1995 provided her with a lump-sum payment of the long-term disability benefits to which she was entitled under the policy.

Even though she eventually obtained her disability benefits, Allinder remained perturbed with the manner in which ICP had attempted to prevent her from receiving what she was due. Allinder consequently filed suit in a Tennessee state court against ICP, alleging conversion, tortuous interference with contractual rights, and misrepresentation in seeking to deprive Allinder of her disability benefits. ICP removed the case to federal court on the basis of a federal question under 28 U.S.C. § 1331. It was subsequently dismissed without prejudice because all of Allinder's state law claims were preempted by ERISA. Allinder then refiled the action in federal court in September of 1996, alleging that ICP's conduct violated ERISA provisions 29 U.S.C. §§ 1132(c), 1104(a)(1), and 1106(b)(2). Allinder pursued her ERISA claims under the civil enforcement provisions contained in § 1132(a)(3) and § 1132(c). In her complaint, Allinder requested only two forms of relief: compensatory damages in the amount of $300,000, and punitive damages in the amount of $300,000.

ICP filed a motion for judgment on the pleadings, contending that (1) Allinder could not make out a cause of action under § 1132(c) because claim forms do not fall within its provisions, (2) Allinder was not entitled to compensatory or punitive damages under § 1132(a)(3) for a violation of § 1104 and § 1106 pursuant to the Supreme Court's decision in *Mertens v. Hewitt Assoc.*, 508 U.S. 248 (1993), and (3) even if she was entitled to some form of monetary relief, Allinder's claims were time-barred. In her memorandum in opposition to ICP's motion, Allinder conceded ICP's second point about the type of damages available under § 1132(a)(3), but maintained nevertheless that she had established a claim for relief under § 1132(c). Because Allinder attached an affidavit in support of her memorandum in opposition, the district court correctly treated ICP's motion as one for summary judgment. *See Security Ins. Co. of Hartford v. Tucker & Assoc., Inc.*, 64 F.3d 1001, 1005 (6th Cir. 1995). After considering the merits of ICP's motion and Allinder's

response, the district court entered summary judgment in favor of ICP. This timely appeal followed.

II. ANALYSIS

A. Standard of Review

We review a district court's order granting summary judgment *de novo*. *Terry Barr Sales Agency, Inc. v. All-Lock Co.*, 96 F.3d 174, 178 (6th Cir. 1996). Like the district court, we must view the entire record in the light most favorable to the non-moving party, taking all reasonable inferences in that party's favor. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587-88 (1986). An entry of summary judgment can only be upheld if "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." FED. R. CIV. P. 56(c).

B. Failure to Fill Out a Claim Form

Allinder devotes much of her brief to the proposition that ICP violated § 1132(c) by failing to complete its portion of the long-term disability claim form. During the relevant time period, section 1132(c) provided in pertinent part as follows:

> Any administrator who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary . . . within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

29 U.S.C. § 1132(c). The thrust of Allinder's argument is that claim forms are among the information that § 1132(c) requires a plan administrator to furnish to plan participants.

Section 1024(b)(4) requires plan administrators to provide the following information to plan participants:

> The administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary plan description, plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or *other instruments under which the plan is established or operated.*

29 U.S.C. § 1024(b)(4) (emphasis added).

Allinder asserts that claim forms fall under § 1024(b)(4)'s provision for "other instruments" because claim forms are necessary to the day-to-day operation of ICP's long-term disability benefit plan. She specifically notes that the insurance company requires that ICP submit completed claim forms before the insurance company will process any disability benefit claims. Allinder would thus have us read the term "other instruments" to include any document that is used in the *day-to-day processing of claims* under an employee benefit plan. Employment records, medical records, identification cards, and other types of evidentiary and processing documents conceivably would also fall within Allinder's construction of the term "other instruments."

Allinder misconstrues the breadth of the term. According to the rule of *ejusdem generis*, when general words follow the enumeration of specific words in a statute, courts are to construe the general words in a manner that limits them to the same class of things enumerated by the preceding specific words. *See United States v. Faudman*, 640 F.2d 20, 23 (6th Cir. 1981). "The rule [gives] effect to both the particular and the general words, by treating the particular words as indicating the class, and the general words as extending the provisions of the statute to everything embraced in that class, though not specifically named by the particular words." 2A SUTHERLAND STATUTORY CONSTRUCTION § 47.17 at 166 (4th

ed. 1984). With this understanding in mind, Allinder's suggested interpretation is not the correct one.

From the statute's enumeration of the specific terms "summary plan description," "plan description," "bargaining agreement," and "contract," it is apparent that "other instruments" was meant to refer to documents that provide or contain information *concerning the terms and conditions of the participant's policy*. In a similar vein, the general term "other instruments" is qualified by the phrase "under which the plan is established or operated." 29 U.S.C. § 1024(b)(4). Section 1024(b)(4)'s reference to "other instruments" is thus properly limited to those class of documents which provide a plan participant with information concerning how the plan is *operated*. Claim forms contain none of these qualities. Instead, claim forms are simply documents used in the *ministerial day-to-day processing* of individual claims pursuant to other documents that determine the plan's operation.

Moreover, ERISA's legislative history indicates that Congress did not intend that claim forms be among the materials covered under § 1132(c). "The reporting and disclosure provisions of [ERISA] were intended specifically to insure that plan participants are able to obtain financial information about the plan, as well as information about the benefits which they are eligible to receive." *Arsenault v. Bell*, 724 F. Supp. 1064, 1066 (D. Mass. 1989). In the House Report accompanying the passage of ERISA, Congress recognized

> a need for a more particularized form of reporting so that the individual participant knows exactly where he stands with respect to the plan—what benefits he may be entitled to, what circumstances may preclude him from obtaining benefits, what procedures he must follow to obtain benefits, and who are the persons to whom the management and investment of his plan funds have been entrusted. . . . [T]he

> safeguarding effect of the fiduciary responsibility section will operate efficiently only if fiduciaries are aware that the details of their dealings will be open to inspection, and that individual participants and beneficiaries will be armed with enough information to enforce their own rights as well as the obligations owed by the fiduciary to the plan in general.

H.R. REP. NO. 533, 93d Cong., 2d Sess. 11 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4649. From this legislative history, it is clear that Congress only intended § 1132(c) "to guarantee that plan participants have *access to the information* they need to protect their interests in the assets and funds being managed by the plan fiduciaries." *Arsenault*, 724 F. Supp. at 1066 (emphasis added). There is nothing in the legislative history to indicate that Congress drafted § 1132(c) to insure that plan fiduciaries faithfully execute their ministerial function of completing claim forms for individual plan participants.

Although this is an issue of first impression in this circuit, we note that every court that has considered the question has agreed that a plan participant may not invoke § 1132(c) to collect penalties from an administrator who fails to supply or complete claim forms. *See Arsenault*, 724 F. Supp. at 1065-67; *Clouatre v. Lockwood*, 593 F. Supp. 1136, 1140 (M.D. La.1984) (plaintiff's "request for benefits does not satisfy the request element that is needed to state a claim upon which relief can be granted under" § 1132(c)); *Wesley v. Monsanto Co.*, 554 F. Supp. 93, 98 (E.D. Mo.1982) ("claim forms are not among the documents specified in the statute."). Because the applicable statutory language, legislative history, and case law demonstrate that claim forms are not among the materials covered by § 1132(c), Allinder cannot make out a claim for a violation of § 1132(c). We therefore affirm the district court's granting of summary judgment in favor of ICP on this claim.

C. Breach of Fiduciary Duty under §§ 1104 and 1106

One issue not addressed by either party concerns the district court's handling of whether Allinder can sue ICP in her individual capacity for the former's alleged violation of § 1104(a)(1) and § 1106(b)(2). The parties instead focus exclusively on the form of relief available under § 1132(a)(3) when there has been a showing of a breach of fiduciary duty under § 1104(a)(1) and § 1106(b)(2). Although we normally decide cases "on the narrow battlefield the parties have chosen," *Mertens v. Hewitt Assoc.*, 508 U.S. 248, 255 (1993), this preliminary question assumes greater importance in this case because the district court's decision rested on its resolution of the standing issue.

Section 1132(a)(3) is the third of "six carefully integrated civil enforcement provisions found in [§ 1132(a)]." *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985). For the period of time relevant to this case, section 1132(a) read in its entirety as follows:

> **(a) Persons empowered to bring a civil action.** A civil action may be brought—
> **(1)** by a participant or beneficiary—
>
> (A) for the relief provided for in subsection (c) of this section, or
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;
> **(2)** by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;
> **(3)** by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any

> provisions of this subchapter or the terms of the plan;
> (4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;
> (5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter; or
> (6) by the Secretary to collect any civil penalty under subsection (i) of this section.

Section 1132(a)(1)(B)'s provisions concerning the recovery of benefits wrongfully denied are not applicable in this case because Allinder eventually did receive the benefits she was entitled to under ICP's policy. If the insurance company had not made a lump-sum payment of benefits to Allinder, § 1132(a)(1)(B) would have provided her a viable avenue for relief.

Instead, Allinder claims that the alleged intentional misrepresentations made by ICP in refusing to complete the claim form constituted a violation of its fiduciary duties under ERISA—specifically, § 1104(a)(1) and § 1106(b)(2). These provisions read in pertinent part as follows:

> **§ 1104 Fiduciary Duties**
>
> **(a) Prudent man standard of care**
>
> (1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—
> (A) for the exclusive purpose of:
> (i) providing benefits to participants and their beneficiaries; and

> (ii) defraying reasonable expenses of administering the plan;
> (B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;
> (C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
> (D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter or subchapter III of this chapter.
>
> **§ 1106 Prohibited Transactions**
>
> **(b) Transactions between plan and fiduciary**
>
> A fiduciary with respect to a plan shall not—
>
> . . . .
>
> (2) in his individual or in any other capacity act in any transaction involving the plan on behalf of a party (or represent a party) whose interests are adverse to the interests of the plan or the interests of its participants or beneficiaries.

The district court, however, did not reach the merits of Allinder's breach of fiduciary duty claim. Instead, it relied on *Tassinare v. American Nat. Ins. Co.*, 32 F.3d 220 (6th Cir. 1994), for the proposition that the fiduciary duties imposed by ERISA on administrators runs only to the plan itself, as opposed to the individual plan participants. *Id.* at 222. Because Allinder sought to recover damages from ICP for her own personal benefit, the district court held that she failed to state a claim for a breach of fiduciary duty under § 1132(a)(3).

Such reliance upon *Tassinare*, however, is misplaced because of the Supreme Court's subsequent decision in *Varity Corp. v. Howe*, 116 S. Ct. 1065 (1996). In *Varity*, the Supreme Court squarely held that § 1132(a)(3) is "broad enough to cover individual relief for breach of a fiduciary obligation." *Id.* at 1076. Accordingly, individual plan participants can now bring suit under § 1132(a)(3) in their individual capacity. *Id.* The district court therefore erred in dismissing Allinder's breach of fiduciary duty claim on the basis that she brought it in her individual capacity. This error does not ultimately inure to Allinder's benefit, however, because her claim for compensatory and punitive damages under § 1132(a)(3)(B)'s provisions for "other appropriate equitable relief"is not viable as a matter of law (see subsection D. below).

D. Compensatory and Punitive Damages Under § 1132(a)(3)

Allinder argues that she is entitled to compensatory and punitive damages under § 1132(a)(3) for ICP's purported breach of fiduciary duty. ICP contends that Allinder has failed to preserve this question for appeal because she conceded in the district court that she was not entitled to such damages. Allinder claimed at oral argument before this court that she did not concede this issue below, but simply failed to argue its merits. Although as a general rule this court will not consider an issue not passed upon below, we have chosen to address this claim because it concerns a purely legal question whose resolution is clear and indisputable. *See Singleton v. Wulff*, 428 U.S. 106, 121 (1976) (finding that "[t]he matter of what questions may be taken up and resolved for the first time on appeal is one left primarily to the discretion of the courts of appeal, to be exercised on the facts of the individual cases.").

Allinder asserts that compensatory damages fall within the term "equitable relief" because such relief traditionally has been allowed in courts of equity where the claim involves a breach of trust. For support, Allinder relies upon Justice

Brennan's concurring opinion in *Massachusetts Mut. Life Ins. Co. v. Russell*, where he noted that "while a given form of monetary relief may be unavailable under ERISA [when it would significantly conflict with some other aspect of the statutory scheme,] it cannot be withheld simply because a beneficiary's remedies under ERISA are denominated 'equitable.'"473 U.S. 134, 154 n.10 (1985). Whatever persuasiveness Justice Brennan's opinion may once have had on this question, it has since been squarely rejected by the Supreme Court's decision in *Mertens v. Hewitt Assoc.*, 508 U.S. 248 (1993). *Mertens* specifically held that § 1132(a)(3)'s reference to "equitable relief" was limited to the "remedy traditionally viewed as 'equitable,' such as injunction or restitution." *Id.* at 255. Because money damages are "the classic form of *legal* relief," § 1132(a)(3) does not authorize suits for compensatory, much less punitive, damages. *Id.*

Accordingly, although Allinder may bring a claim for breach of fiduciary duty in her individual capacity, we nonetheless hold that the district court properly dismissed Allinder's action because the form of remedy sought is not available to her as a matter of law. *See City Management Corp. v. U.S. Chem. Co., Inc.*, 43 F.3d 244, 251 (6th Cir. 1994) (finding that this court may affirm on any grounds supported by the record, even though they may be different grounds than those relied upon by the district court).

E. ICP's Motion for Sanctions

As a final housecleaning matter, we deny ICP's motion for sanctions brought under Rule 38 of the Federal Rules of Appellate Procedure. ICP contends that sanctions are appropriate, in part, because Allinder's "arguments concerning the interpretation of § 1132(c) constitute novel, stubborn legal arguments involving authority which is, at best, only marginally relevant to the issue in dispute, and which is, at worst, completely foreclosed by the controlling precedent of this Circuit." Moreover, ICP argues that Allinder's position with respect to the form of relief that is available under

§ 1132(a)(3) "represents an insistence on litigating a question in the face of controlling precedents which removed every colorable basis in law for Plaintiff's position."

Rule 38 provides that "[i]f a court of appeals determines that an appeal is frivolous, it may . . . award just damages and single or double costs to the appellee." Thus the awarding of sanctions under Rule 38 is predicated upon a finding that (1) the appeal is frivolous, and (2) sanctions are appropriate. *See Depoister v. Mary M. Holloway Found.*, 36 F.3d 582, 588 (7th Cir. 1994). Although the term "frivolous" is not subject to a ready-made definition, generally "[a]n appeal is frivolous when the result is obvious or when the appellant's argument is wholly without merit." *Id.* (quoting *Spiegel v. Continental Ill. Nat. Bank*, 790 F.2d 638, 650 (7th Cir. 1986)). Sanctions are appropriate where "the appeal was prosecuted with no reasonable expectation of altering the district court's judgment and for purposes of delay or harassment or out of sheer obstinacy." *Reid v. United States*, 715 F.2d 1148, 1155 (7th Cir. 1983).

Although we have rejected Allinder's argument concerning the proper interpretation of ERISA's document-disclosure provisions, we do not believe that her arguments were wholly without merit. Allinder did put forward a cognizable, albeit strained, interpretation of § 1024(b)(4) to support her position. ICP has also failed to present any evidence, other than its conclusory statements, that Allinder pursued her appeal with a dilatory motive or in bad faith. Finally, we are troubled by ICP's attempt to punish Allinder when its own hands are not entirely clean in this matter. Indeed, but for the impediment that the *Mertens* decision placed on Allinder's ability to pursue her claim for monetary damages under § 1132(a)(3), the district court's grant of summary judgment for ICP on the fiduciary duty claim would have been inappropriate at this stage in the litigation.

III. CONCLUSION

Many commentators have noted that the Supreme Court's 5-4 decision in *Mertens* has resulted in a "betrayal without a remedy" for employees who pursue ERISA claims beyond the simple recovery of benefits. *See* Jayne Elizabeth Zanglein, *Closing the Gap: Safeguarding Participants' Rights by Expanding the Federal Common Law of ERISA*, 72 WASH. U. L.Q. 671, 671 (1994) (noting that participants are "caught in the vortex of an ever-expanding preemptive black hole, unregulated by ERISA, and unprotected by state law.").

The outcome in this case lends support to such criticism. Allinder would have been entitled to monetary damages under the state-law claims she originally filed. These claims, however, were extinguished by ERISA's "ever-expanding preemptive black hole." Zanglein, *Closing the Gap*, 72 WASH. U. L.Q. at 674. ERISA, in turn, provides infertile soil for an employee to cultivate a meaningful remedy for anything beyond the recovery of basic benefits. Employees may seek monetary damages on behalf of the *plan* for an employer's breach of fiduciary duty. *See Russell*, 473 U.S. at 139-40. They may not, however, seek similar relief for their own benefit when an employer breaches its fiduciary duty. *Mertens*, 508 U.S. at 258. Instead, employees are left with the often-inadequate remedy of an injunction, imposition of a constructive trust, or the removal of the fiduciary. "In this way, the combination [of the employee's] state cause of action [being] preempted by ERISA even while ERISA denies him any alternative remedy . . . is disappointingly pernicious to the very goal and desires that motivated Congress to enact [ERISA] in the first place." *Sanson v. General Motors Corp.*, 966 F.2d 618, 625 (11th Cir. 1992) (Birch, J., dissenting).

Constrained as we are by both ERISA's statutory provisions and the Supreme Court's construction of that language, this case provides no opportunity for us to redress the problems that employees face when pursuing a remedy under ERISA for an employer's or insurer's misdeeds beyond the recovery

of the basic benefits to which they are entitled. Accordingly, we **AFFIRM** the judgment of the district court.

Case No: 97-5909

UNITED STATES COURT OF APPEALS

FOR THE SIXTH CIRCUIT

ORDER

LINDA ALLINDER

Plaintiff - Appellant

FILED

v.

August 31 1998

INTER-CITY PRODUCTS CORPORATION (USA); ROBERT HENNINGSEN

LEONARD GREEN, Clerk

Defendants - Appellees

BEFORE: MOORE, CLAY and GILMAN, Circuit Judges

Upon consideration of the petition for rehearing filed by the appellant,

It is ORDERED that the petition for rehearing be, and it hereby is, DENIED.

ENTERED BY ORDER OF THE COURT

_____

Leonard Green, Clerk

Supreme Court, U.S.
FILED
JAN 29 1999
CLERK

No. 98-1049

IN THE

Supreme Court of the United States

OCTOBER TERM, 1998

LINDA ALLINDER,

Petitioner,

v.

INTER-CITY PRODUCTS CORPORATION (USA)
AND
ROBERT HENNINGSEN,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether Petitioner may properly challenge, at this stage of her case, the lower courts' conclusions that Respondent Inter-City Products Corporation (USA)'s long-term disability insurance policy constitutes a "welfare benefit plan" and that Respondents constitute "fiduciaries" under the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and, if so, whether the lower courts were correct, based on the record before them, in so concluding.

2. Whether Petitioner may properly assert that her claims under ERISA, which both the District Court and Court of Appeals addressed on the merits and which the Court of Appeals held constituted "a cognizable . . . interpretation" of the statute, were instead so insubstantial, implausible, foreclosed by prior decisions of this Court, or otherwise devoid of merit as to deprive the lower courts of jurisdiction over the matter.

3. Whether the Court of Appeals correctly concluded that Petitioner's claims under ERISA Section 502(a)(3) were subject to this Court's holding in *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993), limiting potential remedies under Section 502(a)(3) to "appropriate equitable relief," which excludes money damages such as compensatory and punitive damages.

4. Whether Petitioner may seek, at this stage of her case and on the record developed below, relief that was not ruled upon by the lower courts, and, if so, whether she may appropriately characterize money damages for fees paid her attorney and interest associated with her receipt of benefits as equitable "restitution" in light of this Court's decisions and settled principles of law to the contrary.

RULE 29.6 STATEMENT OF AFFILIATED CORPORATIONS

Respondent Inter-City Products Corporation (USA), now known as International Comfort Products Corporation (USA), is a wholly-owned subsidiary of International Comfort Products Corporation. Respondent Inter-City Products Corporation (USA) holds an interest in its non-wholly-owned subsidiary, Frigoram Commerciale S.p.A.

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The opinion of the United States Court of Appeals for the Sixth Circuit in this case, *Allinder v. Inter-City Products Corp. (USA)*, 152 F.3d 544 (6th Cir. 1998), was reproduced as "Appendix A" to the Petition for Writ of Certiorari at A1. The unreported order of the Court of Appeals denying rehearing was reproduced as "Appendix B" to the Petition for Writ of Certiorari at A20. The unreported opinion of the United States District Court for the Middle District of Tennessee in this case is reproduced verbatim as "Appendix A" hereto at A1, and the unreported opinion of the District Court in Petitioner's prior related action is reproduced verbatim at A9.

STATEMENT OF THE CASE

Petitioner's claims arise from her efforts to secure benefits under an insured, group long-term disability ("LTD") plan maintained by Respondent Inter-City Products Corporation (USA) ("Inter-City") for the benefit of its employees. After Petitioner's initial effort to claim LTD benefits was denied by Inter-City, she abandoned the established claim review process and instead attempted to deal directly with the insurance company with whom Inter-City contracted for group benefits. Although Petitioner ultimately recovered the full value of her LTD benefits, she thereafter sued Inter-City asserting that it had breached various duties to her by initially denying her claim.

In her Petition for Writ of Certiorari ("Petition"), as in her pleadings below, Petitioner confuses the procedural history of this case with an earlier, failed lawsuit against Inter-City. As described by the Court of Appeals, Petitioner initially filed suit against Inter-City in Tennessee state court seeking compensatory and punitive damages under a variety of state law theories. *See* Petitioner's Appendix ("Pet. App.") at A7. Because Petitioner's claims in this initial suit related directly to Inter-City's employee group LTD plan, Inter-City properly and timely removed Petitioner's initial suit to the District Court on the grounds that the Employee Retirement Income Security Act of 1974, as amended,

29 U.S.C §§ 1001 - 1461 ("ERISA") preempted her state law claims and provided the exclusive source of any remedy to which she might have been entitled. Thereafter, the District Court denied Petitioner's request that the case be remanded and granted Inter-City's motion for summary judgment on ERISA preemption grounds, dismissing Petitioner's case without prejudice to the refiling of claims she may have had under ERISA. Pet. App. at A7; Respondents' Appendix ("Resp. App.") at A1-2, A13. Petitioner did not appeal or otherwise challenge the District Court's final judgment in this initial action, and the time for doing so has since run.

Rather than further pursuing her state-law claims, Petitioner filed the instant case in the District Court under ERISA seeking compensatory and punitive damages.[1] As detailed by the Court of Appeals in its statement of the case, Respondents sought judgment on the pleadings, pointing out, *inter alia*, that ERISA's exclusive civil enforcement scheme does not allow for the extra-contractual damages sought by Petitioner. Pet. App. at A7. In her responsive pleadings, as the Court of Appeals noted, Petitioner "conceded [Inter-City's] . . . point about the type of damages available under [ERISA]." *Id.*; *see also* Resp. App. at A3-4. Treating the motion as one for summary judgment, and based in part on Petitioner's prior concession, the District Court entered judgment for Respondents. Resp. App. at A8. The Court of Appeals affirmed, concluding that under this Court's precedent in *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993), Petitioner's "claim for compensatory and punitive damages under [ERISA] § 1132(a)(3)(B)'s provisions for 'other appropriate equitable relief' is not viable as a matter of law." Pet. App. at A15. Thereafter, Petitioner requested a rehearing, contending for the first time—in the guise of a jurisdictional challenge—that Inter-City's LTD benefit plan was *not* subject to ERISA and further challenging the lower courts' characterizations of Respondents as ERISA fiduciaries. The Court of Appeals denied Petitioner's request. Pet. App. at A20.

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[1] Petitioner added Respondent Robert Henningsen as a defendant in this action.

REASONS FOR DENYING THE WRIT

Petitioner raises no question appropriate for this Court's review. Rather, dissatisfied with the result reached in the District Court and affirmed by the Court of Appeals, she seeks merely to re-litigate her claims before this Court in the context of certiorari. Although she attempts to cloak her dissatisfaction in terms of subject matter jurisdiction and attenuated distinctions between controlling precedents, at its core her Petition fails to identify any issue worthy of the writ she seeks. The jurisdictional question she alleges is nothing more than an effort—at this late stage of the case and after Petitioner herself invoked ERISA as the basis for her suit—to have the Court re-examine the factual conclusions that Inter-City's LTD arrangement is an ERISA-governed benefit plan and that Respondents acted as fiduciaries of that plan. To prevail, moreover, this challenge requires Petitioner to take the ironic position that her own ERISA claims are so devoid of merit as not to involve a legitimate federal controversy. Similarly, Petitioner's misplaced attempt to distinguish her case from this Court's ERISA precedent merely seeks to have the Court second-guess the application of that precedent to the factual record below. Finally, her newly-raised suggestion that the money damages she seeks can be reconciled with ERISA's remedial scheme of "appropriate equitable relief" comes not only too late in the case, but runs counter to this Court's decisions and well-settled principles of law. In short, Petitioner has failed to identify any compelling basis on which to grant the writ she seeks.

I. Petitioner's Challenge to Subject Matter Jurisdiction Inappropriately Attempts to Re-Litigate Threshold Factual Determinations by the Lower Courts and, in Any Event, Fails This Court's "Substantiality" Standard.

Throughout this case, Petitioner has specifically relied on ERISA as the basis for her claims, advancing alternative theories of liability under that federal statute before the District Court and Court of Appeals. Now, however, having seen each of her theories rejected, Petitioner has abruptly recanted her reliance

on ERISA and suggested for the first time that the lower courts lacked subject matter jurisdiction over her claims. Petition at 3-4. Through her sudden change of heart, Petitioner would have this Court wipe away the results not only of this case but also of her prior litigation, freeing her to bring a *third* attempt at the recovery that has eluded her thus far. In playground parlance, Petitioner seeks a "do-over."

Petitioner's "jurisdictional" challenge does not truly question the District Court's authority to hear ERISA claims. Rather, Petitioner questions whether the *facts* of this case support such a claim—challenging the premises that Inter-City's LTD benefit policy is an ERISA-governed plan and that Respondents are ERISA fiduciaries and instead suggesting that Inter-City's purchase of an insurance policy took it outside ERISA's scope.[2] As such, her challenge is not so much a question of jurisdiction as it is an attempt to have this Court re-litigate threshold factual issues properly resolved by the courts below. *See, e.g.,* Resp. App. at A11 (finding ERISA preemption in Petitioner's prior case because "Plaintiff's claims against the Defendant . . . clearly 'relate to' the benefit plan."); A4 (referring in the present case to "ERISA welfare benefit plans like Defendant's . . . plan").

Certiorari is rarely an appropriate means to review fact-bound determinations by the lower courts such as those challenged by Petitioner. *See General Talking Pictures Corp. v.*

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[2] Typical of Petitioner's arguments is her suggestion that "insurance companies cannot be a benefit plan or a trust established under the plan, unless the plan's primary purpose is to provide death benefits." Petition at 7-8. Rather than address ERISA's trust requirements or the fiduciary status of insurers, however, the authority cited for this proposition, 29 U.S.C. § 1144(b)(2)(A), deals with ERISA's preemption of state law. Similarly, Petitioner suggests that the state-law claims in her prior case should not have been dismissed because Respondents did not affirmatively state they were ERISA fiduciaries. Petition at 10. Not only is the time for any challenge to Respondents' fiduciary status long past, but the decisions upon which Petitioner relies—assuming they ever had any application here—were overruled *sub silentio* by this Court in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (state-law claims for tortious breach of agreement or bad faith benefit denial are preempted by ERISA where they "relate to" a covered benefit plan).

Western Elec. Co., 304 U.S. 175, 178 (1938) ("Granting of the writ would not be warranted merely to review the evidence or inferences drawn from it."); Sup. Ct. R. 10 (writ "is rarely granted when the asserted error consists of erroneous factual findings or the misapplication of a properly stated rule of law"). This is particularly true where, as here, the fact determinations are consistent with well-settled law.[3] *See, e.g., Donovan v. Dillingham*, 688 F.2d 1367, 1373 (11th Cir. 1982) ("the purchase of a group policy . . . covering a class of employees offers substantial evidence that a plan, fund, or program has been established"); *see also Kidder v. H & B Marine, Inc.*, 932 F.2d 347, 352-53 (5th Cir. 1991) (per curiam) (narrowly restricting ERISA exception, relied upon by Petitioner, for certain group insurance arrangements); 29 U.S.C. § 1103(b) (excluding insured ERISA welfare benefit plans like Inter-City's from trust requirements); *cf.* 29 C.F.R. § 2510.3-1(j) (1998) (describing limited circumstances, not applicable here, in which certain insurance arrangements fall outside ERISA's application). To depart from that standard here would allow Petitioner, through her "jurisdictional" challenge, to re-open not only the lower courts' fact determinations in this case but also the unappealed and now-final ruling of ERISA preemption by the District Court in Petitioner's original, dismissed case.

Moreover, even if Petitioner legitimately raised a question of subject matter jurisdiction, her argument would fail under this Court's long-standing test of "substantiality." In essence, Petitioner suggests that, although she pled claims exclusively under ERISA, the facts as she now understands them will not support

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[3] By its terms, ERISA governs "any employee benefit plan if it is established or maintained . . . by any employer engaged in commerce or in any industry or activity affecting commerce . . . ." ERISA § 4(a); 29 U.S.C. § 1003(a). Covered plans include "any plan, fund or program . . . established or maintained by an employer . . . to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, *through the purchase of insurance or otherwise*, . . . benefits in the event of . . . disability . . . ." ERISA § 3(1); 29 U.S.C. § 1002(1) (emphasis added).

her recovery under that statute. As Justice Holmes noted, however, it is well-settled that "when the plaintiff bases his cause of action upon an act of Congress, jurisdiction cannot be defeated by a plea denying the merits of the claim." *The Fair v. Kohler Die & Specialty Co.*, 228 U.S. 22, 25 (1913). Rather, in cases involving federal statutes, "[j]urisdiction is authority to decide the case either way." *Id.* Thus, as recently reaffirmed by this Court, subject matter jurisdiction exists over federal claims unless those claims cannot be said to raise a substantial issue under federal law:

> It is firmly established in our cases that the absence of a valid (as opposed to arguable) cause of action does not implicate subject-matter jurisdiction .... As we stated in *Bell v. Hood*, 327 U.S. 678, 682, 66 S. Ct. 773, 776, 90 L. Ed. 939 (1946), "[j]urisdiction ... is not defeated ... by the possibility that the averments might fail to state a cause of action on which petitioners could actually recover." Rather, the District Court has jurisdiction if "the right of petitioners to recover under their complaint will be sustained if the Constitution and laws of the United States are given one construction and will be defeated if they are given another," ... unless the claim "clearly appears to be immaterial and made solely for the purpose of obtaining jurisdiction or where such a claim is wholly insubstantial and frivolous." ... *Dismissal for lack of subject-matter jurisdiction because of the inadequacy of the federal claim is proper only when the claim is "so insubstantial, implausible, foreclosed by prior decisions of this Court, or otherwise completely devoid of merit as not to involve a federal controversy."*

Steel Co. v. Citizens for a Better Environment, 118 S. Ct. 1003, 1010 (1998) (internal citations omitted) (emphasis added).

As a matter of logic, this substantiality standard must apply with at least equal force where it is the party asserting the federal

claim who impugns its viability. Thus, Petitioner's "jurisdictional" argument places her in the awkward position of suggesting that her own claims under ERISA were, upon reflection, "so insubstantial, implausible, foreclosed by prior decisions of this Court, or otherwise completely devoid of merit" as to now warrant dismissal for absence of a legitimate federal controversy. This attempt to escape an unfavorable outcome in her case is precluded, however, by the fact that Petitioner not only chose to plead exclusively claims under ERISA, Pet. App. at 2, but also "put forward a cognizable . . . interpretation of [the statute] to support her position." Pet. App. at A17. As this Court noted in refusing to consider a similar, after-the-fact challenge to subject matter jurisdiction:

> Were it in truth a contention that the District Court lacked jurisdiction, we would be obliged to consider it, even as we are obliged to inquire *sua sponte* whenever a doubt arises as to the existence of federal jurisdiction. . . . However, . . . jurisdiction is sufficiently established by allegation of a claim under the Constitution or federal statutes, unless it "clearly appears to be immaterial and made solely for the purpose of obtaining jurisdiction . . . ." The claim . . . is not so patently without merit as to fail [this] test . . . . Therefore, the question as to whether the respondent stated a claim for relief . . . is not of the jurisdictional sort which the Court raises on its own motion.

Mt. Healthy City School Dist. Bd. of Educ. v. Doyle, 429 U.S. 274, 278-79 (1977) (internal citations omitted), *superseded on other grounds by statute as stated in Rivera v. United States*, 924 F.2d 948 (9th Cir. 1991).

II. Petitioner Offers No Compelling Reason to Review the Application of this Court's Prior Decisions That "Appropriate Equitable Relief" Under ERISA Section 502(a)(3) Does Not Include Recovery of Money Damages.

As an alternative to her jurisdictional challenge, Petitioner suggests that the Court of Appeals misapplied this Court's construction of the remedies authorized under ERISA Section 502(a)(3). Specifically, Petitioner contends that, if Respondents are ERISA fiduciaries, her case is distinguishable from this Court's prior holding that recovery under Section 502(a)(3) is limited to traditionally equitable relief which excludes money damages. Petition at 11-13. Like her attempt to re-litigate the status of Inter-City's LTD plan under ERISA, an effort to revisit the facts underlying Respondents' fiduciary status at this stage of the case does not provide a compelling basis for the writ Petitioner seeks. *See supra* at 4-5. More importantly, however, Petitioner's perceived distinction between fiduciaries and nonfiduciaries for purposes of the relief she seeks is misplaced. As the Court of Appeals correctly observed, Petitioner's sole potential remedy for alleged breach of Respondents' duties of prudence and loyalty under ERISA Sections 404 and 406, 29 U.S.C. §§ 1104(a)(1), 1106(b)(2), is under ERISA Section 502(a)(3), 29 U.S.C. § 1132(a)(3). Pet. App. at A13-14. In applying Section 502(a)(3) to Petitioner's claims, however, the Court of Appeals noted that this Court has limited the forms of relief authorized to exclude money damages:

> *Mertens* specifically held that § 1132(a)(3)'s reference to "equitable relief" was limited to the "remedy traditionally viewed as 'equitable,' such as injunction or restitution." Because money damages are "the classic form of *legal* relief," § 1132(a)(3) does not authorize suits for compensatory, much less punitive, damages.

Allinder, 152 F.3d at 552, Pet. App. at A16 (quoting *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 255 (1993)) (internal citations omitted).

Petitioner challenges this straight-forward application of controlling precedent on the basis that *Mertens* involved a Section 502(a)(3) claim not against a fiduciary but rather against a nonfiduciary who knowingly participated in a fiduciary's breach of its ERISA duties. Yet nothing in *Mertens* distinguishes, for purposes of the relief available under Section 502(a)(3), between a fiduciary and a nonfiduciary who knowingly participates in the former's breach.[4] Rather, *Mertens* simply makes clear that the term "appropriate equitable relief" serves to limit the remedies available under Section 502(a)(3), 508 U.S. at 257-58, and that, consistent with this limitation on available remedies, fiduciaries as well as nonfiduciaries, "assuming [they] can be sued under § 502(a)(3), may be enjoined from participating in a [fiduciary] breach, compelled to make restitution, and subjected to other equitable decrees." *Id.* at 262; *see also Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 53 (1987) ("Under the civil enforcement provisions of § 502(a) . . . [r]elief may take the form of accrued benefits due, a declaratory judgment on entitlement to benefits, or an injunction against a plan administrator's improper refusal to pay benefits.").

Not only has Petitioner failed to articulate a rationale for why the distinction she proposes between fiduciaries and participating nonfiduciaries would have impacted the Court of Appeal's application of *Mertens*, but she has failed as well to reconcile the proposed distinction with this Court's subsequent decision in *Varity Corp. v. Howe*, 516 U.S. 489 (1996). There, the Court expressly dealt with an employer acting in the capacity of plan administrator and fiduciary. *Id.* at 501-03. In concluding that individual beneficiaries and participants could pursue recovery under Section 502(a)(3) for fiduciary breaches, the Court reaffirmed that such recovery is limited to "appropriate equitable relief." *Id.* at 515 (citing, *inter alia*, *Mertens*, 508 U.S. at

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[4] Indeed, the Court noted that, for purposes of its decision, it had accepted the parties' assumption that ERISA Section 502(a)(3) applied equally to fiduciaries and nonfiduciaries who knowingly participate in their breach, despite "the oddity of resolving a dispute over remedies where it is unclear that a remediable wrong has been alleged . . . ." *Mertens*, 508 U.S. at 254.

263-64). Thus, even if the Court of Appeals had considered Petitioner's proposed distinction, it would have undoubtedly reached the same conclusion: that "legal" remedies such as money damages are not among the forms of relief available under ERISA Section 503(a)(3). Accordingly, no compelling reason exists for this Court to revisit the issue.

III. Petitioner's Recharacterization of the Relief She Seeks as "Restitution," Which She Failed to Properly Raise Below, Is Contrary to Both Her Own Prior Position in this Case and Well-Settled Principles of Law.

Perhaps in recognition that the relief she sought below—compensatory and punitive damages—falls beyond the remedies authorized by the plain language of ERISA Section 502(a)(3) and this Court's decisions under that provision, Petitioner now contends that portions of the remedy she seeks are, in fact, equitable in nature. Specifically, Petitioner contends that recovery of fees paid to her attorney and interest on the LTD benefits she eventually received should be viewed as an equitable remedy in the nature of "restitution." Petition at 13-14. This contention was never raised in the District Court, and accordingly was not considered by the Court of Appeals. *Singleton v. Wulff*, 428 U.S. 106, 120 (1976) ("It is the general rule, of course, that a federal appellate court does not consider an issue not passed upon below."). Thus, the issue is inappropriate for discretionary review by this Court. *See Walters v. City of St. Louis, Mo.*, 347 U.S. 231, 233 (1954) ("Of course, we will not undertake to review what the court below did not decide.").

Moreover, Petitioner's argument would require this Court to ignore her concession in the District Court, in response to Respondents' motion for judgment on the pleadings, that Section 502(a)(3) does not authorize recovery of "extra-contractual" damages, *i.e.*, those beyond her actual benefits under the LTD plan. Pet. App. at A7; Resp. App. at A3-4. As one appellate court has observed, "a plaintiff in his opposition to a motion for summary judgment cannot abandon an issue and then, after an unpalatable decision by the trial judge, on appeal, by drawing on the pleadings resurrect the abandoned issue."

Edward B. Marks Music Corp. v. Continental Record Co., 222 F.2d 488, 492 (2d Cir. 1955). By the same reasoning, certiorari is hardly the appropriate context to "resurrect" Petitioner's "abandoned issue" that monetary relief beyond actual plan benefits is available under ERISA Section 502(a)(3).

Finally, Petitioner's contention does not present a compelling issue calling for this Court's resolution. To the contrary, despite the label of "restitution," the recovery Petitioner seeks is, in essence, an award of money in addition to her benefits under the plan to compensate her for alleged losses associated with her initial benefit denial.[5] In contrast to the relief Petitioner seeks, the traditional remedy of restitution involves a return of improperly received benefit or profit. Thus, true restitution is appropriate "only to the extent that [the claimant] has conferred a benefit on [the defendant] by way of part performance or reliance." Restatement (Second) of Contracts § 370 (1979). Here, however, neither the record nor Petitioner's newly-raised argument identifies any unjust enrichment to Respondents at Petitioner's expense. Accordingly, in the absence of some unfair benefit derived by Respondents, there is nothing to be returned to Petitioner in the form of restitution. Restatement of Restitution § 1 (1936).[6] Rather, Petitioner's contention is nothing more than an effort to shoe-horn her request for extra-contractual money damages into ERISA Section 502(a)(3)'s language authorizing "appropriate equitable relief." Rejecting a similar effort in *Mertens*, this Court observed:

> Although they often dance around the word, what petitioners in fact seek is nothing other than compensatory damages—monetary relief for . . . losses . . . sustained as a result of the alleged breach of fiduciary

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[5] This is necessarily so, since Petitioner has admitted that she received her full disability benefits. Pet. App. at A13.

[6] *See also Mertens v. Hewitt Assocs.*, 948 F.2d 607, 612 (9th Cir. 1991) (restitution barred under ERISA by failure to allege unjust enrichment and failure of plaintiff to have conferred a benefit upon defendant), *aff'd*, 508 U.S. 248 (1993); *First Nat'l Life Ins. Co. v. Sunshine-Jr. Food Stores, Inc.*, 960 F.2d 1546, 1553 (11th Cir. 1992) (denying restitution under ERISA where employer received no unjust enrichment).

> duties. Money damages are, of course, the classic form of *legal* relief.

508 U.S. at 255. Accordingly, Petitioner's newly-conceived attempt to characterize her alleged damages as restitution cannot justify the writ she seeks.

CONCLUSION

Petitioner has identified no disagreement among the lower courts, departure from this Court's prior decisions, or similar compelling justification for the writ she seeks. Rather, her Petition is founded upon strained challenges to fundamental fact determinations by the lower courts in applying well-settled law and tenuous distinctions—in many cases contrary to her position below or raised for the first time only on review—offered in an effort to escape the controlling results of this Court's prior decisions. Despite such contentions, however, Petitioner has not demonstrated that her claims were not fully considered and correctly decided on the merits below, much less that the case presents compelling issues of such broad application and jurisprudential significance as to require the Court to settle "an important question of federal law." Sup. Ct. R. 10. For the foregoing reasons, Respondents respectfully request that the Petition for Writ of Certiorari be denied.

DATED: January 28, 1999

Respectfully submitted,

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IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF TENNESSEE NASHVILLE DIVISION

LINDA ALLINDER	)	
	)	
v.	)	No. 3:96-0834
	)	
INTER-CITY PRODUCTS CORP. (USA), ET AL.	)	

MEMORANDUM

Pending before the Court is Defendant's Motion for Judgment on the Pleadings, filed on October 3, 1996. (Doc. No. 5). Upon review of the record, and for the reasons stated below, the Court grants the Motion and dismisses the above-captioned matter.

I. BACKGROUND

Plaintiff Linda Allinder, a former employee of Defendant Inter-City, originally brought this matter in January of 1996 as an action in state court. Plaintiff charged Inter-City with refusing to complete and process forms required for Allinder to obtain insurance benefits after Allinder suffered a toxic reaction to pesticides used in her workplace. Defendant removed the case to federal court in March of 1996, on the grounds that the Plaintiff's claims were "all actions founded upon or preempted by the laws of the United States, specifically, the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001-1461. (1982)."

Plaintiff next filed a Motion for an Order Remanding the Action to State Court, arguing that the action did not emcompass any federal claims that would require the District Court to maintain jurisdiction. Allinder argued that the case be remanded on the grounds that state law predominately governed the circumstances as alleged, since tortious interference with contractual rights, misrepresentation, and conversion are "well founded State common law causes of action."

The Court denied Plaintiff's Motion to Remand and entered Summary Judgment on the grounds that Plaintiff's state law claims were preempted by federal law under ERISA. Plaintiff had failed to state a claim on which relief could be granted, since Plaintiff's state law claims were preempted by ERISA. Thus, this Court dismissed the case without prejudice in August of 1996.

Plaintiff refiled the action in Federal Court in September of 1996, alleging an ERISA violation arising from defendant Inter-City and Defendant Henningsen's interference with her claim processing by failing to complete forms necessary for Plaintiff's filing of a long term disability insurance claim.

II. DISCUSSION

A. Standard of Review.

Initially, the motion was filed as a Motion for Judgment on the Pleadings. The standard for such a motion requires that a complaint may be dismissed only if it is clear that no relief could be granted under any set of facts that could be proved consistent with the allegations. Defendant maintains that since Plaintiff has filed a Response to Defendant's Motion for Judgment on the Pleadings, together with a Memorandum and an Affidavit, Plaintiff has effectively transformed Defendants' motion for judgment on the pleadings into a motion for summary judgment. FRCP Rule 12 states, "If, on a motion for judgment on the pleadings, matters outside the pleadings are presented to and not excluded by the court, the motion shall be treated as one for summary judgment and disposed of as provided in Rule 56." Thus, this Court will evaluate Defendants' Motion for Judgment on the Pleadings as a Motion for Summary Judgment.

Summary judgment is appropriate where "there is no genuine issue as to any material fact and . . . the moving party is entitled to a judgment as a matter of law." Fed.R.Civ.P. 56(c). In ascertaining whether summary judgment is proper, the Court views the facts and any reasonable inferences drawn from those

facts in a light most favorable to the non-moving party. *Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 157 (1970). However, on its own, the existence of a colorable factual dispute will not defeat a properly supported motion for summary judgment. A genuine dispute between the parties on an issue of material fact must exist to render summary judgment inappropriate. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-49 (1986) (internal citations omitted). In order to survive a motion for summary judgment, the Plaintiff must produce more than a scintilla of evidence. The Supreme Court, in *Anderson v. Liberty Lobby* stated that "[t]the mere existence of a scintilla of evidence in support of the plaintiff's position will be insufficient; there must be evidence on which the jury could reasonably find for the plaintiff. *Anderson*, 477 U.S. at 248, 252; *see also Street v. J.C. Bradford & Co.*, 886 F. 2d 1472, 1479 (6th Cir. 1989), *reh'g denied* 1990.

In construing the evidence in its most favorable light in favor of Plaintiff and against Defendants, as required under *Bohn Aluminum & Brass Corp. v. Storm King Corp.*, 303 F.2d 425, 427 (6th Cir. 1962), the Court finds that there does not exist a genuine issue of material fact with respect to the question of the viability of Plaintiff's claims. Thus, after a careful review of the record, the Court, in this instance, believes summary judgment to be appropriate.

B. The availability of compensatory, punitive, or extra contractual damages:

Defendant alleges that Plaintiff has failed to state a claim for which relief may be granted because the tort claims she alleges are not included in ERISA's exclusive civil enforcement scheme. In Plaintiff's Amended complaint, she states only causes of action under ERISA. Plaintiff's complaint prays that this Court award her $300,000 in compensatory damages and $300,000 in punitive damages. However, Defendants' in their Motion for Judgment on the Pleadings, argued that since ERISA's civil enforcement scheme does not provide for causes of

action in tort, Plaintiff has failed to state a cause of action on which relief may be granted.

Plaintiff concedes in her Response to Defendant's Motion for Judgment on the Pleadings (Doc. No. 9) that ERISA does not provide compensatory, punitive, or extracontractual damages to redress Plaintiff's asserted claims. However, she maintains that she has shown sufficient facts in the complaint to establish a claim for relief under 29 U.S.C. Section 1132 and for Defendants' breach of their fiduciary duties towards Plaintiff.

C. Did Defendants violate ERISA when they failed to process Plaintiff's disability insurance forms?

Plaintiff contends that Defendants violated ERISA at 29 USCS 1132(c) by failing to fill out the employer portion of Plaintiff's long term disability form. Additionally, Plaintiff maintains that Defendants violated ERISA at 29 USCS 1104(a)(1) and 1106(b)(2) in its failure to meet its duties as a plan fiduciary. The Court will examine each of these arguments in turn.

29 USCS 1132(c) provides that:

> Any administrator who fails or refuses to comply with a request for any information which such administrator is required by this sub chapter to furnish to a participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount up to $100.00 a day from the day of such failure or refusal, and the court may at its discretion order such relief as it deems proper.

ERISA at 29 USC 1024(b)(4) requires plan administrators to provide the following information to the participants of ERISA welfare benefit plans, like Defendant's ICP plan: (1) a summary plan description; (2) annual report; (3) a summary description of plan modifications; and (4) upon written request by the participant, a copy of any collective bargaining agreement, trust agreement, contract or other instruments under which the plan is established or operated.

Plaintiff argues that "the request by the Plaintiff that the Defendant fill out their portion of the Long Term disability form is certainly a request for an instrument under which the plan is operated. The form is the mechanism by which benefits are requested for the participant. At the top of one side of the form are the instructions, "TO BE COMPLETED BY THE EMPLOYER." Plaintiff's Memorandum, p. 3. Additionally, the disability insurance policy states, "The Insurance Company will deal solely with the policyholder who will be deemed the representative of each employee." An amendment to the policy states, "The name of the Policyholder is changed to Inter-City Products Corporation." Thirdly, according to Plaintiff, the insurance company informed Plaintiff originally, verbally, and later in a January 20, 1994 letter, that before they could process her claim, her employer must fill out his side of the form.

Defendant contends that in order to establish a violation of 29 USC 1132(c), Plaintiff must show (1) that the plan administrator was required by ERISA to make available to the participant the information she requested, and (2) that the participant requested in writing, and the administrator failed or refused to provide the information. *Kleinhans v. Lisle Sav. Profit Sharing Trust*, 810 F.2d 618, 622 (7th Cir. 1987). On this basis, Defendants argue that the plan administrator's conduct and intent have no bearing on the court's determination whether its discretionary power to award a penalty under 29 USC 1132(c) has been triggered.

Additionally, Defendant argues that claim forms are not instruments under which the Plan is operated under ERISA section 502(c). According to Defendant, every court which has considered Plaintiff's argument that claim forms and the employment information requested on Plaintiff's form are "instruments under which a plan is operated" under 29 USC 1024 (b)(4), has, in each and every case, held in opposition to Plaintiff's position, finding instead that such forms are not within the scope of ERISA section 502(c).

The Court, having reviewed the caselaw on the question as to whether claim forms or Plaintiff's requested employment information constitute "instruments under which a plan is operated" under 29 USC 1024(b)(4), conclude that the majority of the authority supports Defendant's position. *See, e.g., Wesley v. Monsanto Co.*, 554 F. Supp. 93, 98 (E.D. Mo. 1982), *affirmed*, 710 F.2d 490 (8th Cir. 1983) (stating that claim forms are not among the documents specified in the statute); *Arsenault v. Bell*, 724 F. Supp. 1064, 1066 (D. Mass 1989) ("A plan participant may not invoke section (c) to collect penalties from an administrator who fails to supply the forms"). The Sixth Circuit has not ruled upon the issue explicitly, but has noted that "there is some question as to whether claim forms are even covered under ERISA's document production requirements." *Osimowicz v. Ford Motor Co.*, 9 F. 3d 109, n. 4 (6th Cir. 1993). Defendant argues as well that ERISA 502(c) does not require Defendants to provide employment records to Plaintiff. *See, e.g., Vernon v. C.K. Systematics, Inc.*, 1987 WL 5276, at 6 (E.D. Pa. 1987) (noting that it is extremely doubtful that ERISA plan administrators are required to supply such information). Thus, the Court rejects Plaintiff's argument that Defendants' conduct violated ERISA at USCS 1132(c).

Plaintiff additionally argues in support of her claim that Defendants violated ERISA at 29 USCS 1104(a)(1) and 1106(b)(2) in its failure to meet its duties as a plan fiduciary. Plaintiff cites a Supreme Court holding indicating that not all powers and duties of trustees and their fiduciaries are explicitly enumerated; rather, the general scope of authority and responsibility is defined by the common law of trust, under which trustees are understood to have all powers necessary or appropriate for carrying out the purposes of the trust. *Central States, Southeast and Southwest Areas Pension Fund v. Central Transport. Inc.* 472 U.S. 559, 568-574 (1985). According to Plaintiff, ERISA 29 USCS 1104(a)(1) and 1106(b)(2) impose upon fiduciaries of employee benefit plans duties of loyalty and prudence. These statutory provisions, according to Plaintiff, indicate that a fiduciary shall not "in his individual or any other capacity act in any

transaction involving the plan on behalf of a party (or represent a party) whose interests are adverse to the interest of the plan or the interest of the beneficiaries." *Evans v. Bexley*, 750 F.2d 1498, 1499 (11th Cir. 1985). Fiduciary standards of ERISA, contends Plaintiff, must be enforced with uncompromising rigidity. *Donovan v. Estate of Fitzsimmons*, 778 F.2d 298, 302 (7th Cir. 1985). Trustees must act for the exclusive purposes of providing benefits for participants and their beneficiaries, and defraying reasonable expenses of administration within the trust. *Clark v. Washington Teamsters Welfare Trust*, 8 F.3d 1429, 1432 (9th Cir. 1993). Fiduciary duties articulated in 29 USCS 1104 are not exhaustive, rather, Congress relied upon common law trust to define the general scope of the trustees' and other fiduciaries' authority and responsibility. *Bixler v. Central Pennsylvania Teamsters Health & Welfare Fund* 12 F.3d 1292, 1299 (3rd Cir. 1993).

Unfortunately for Plaintiff, the Sixth Circuit has been explicit in its rejection of claims brought by individual plan participants claiming the breach of a fiduciary duty by a plan administrator. As the Court in *Tassinare v. American Nat. Ins. Co.* states,

> It is well-settled that fiduciary liability under ERISA arises in favor of the plan itself, and that plan participants may not seek to recover in an individual capacity. *See Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 140-44, 105 S.Ct. 3085, 3089-91, 87 L.Ed.2d 96 (1985); *Tregoning v. American Community Mut. Ins. Co.*, 12 F.3d 79, 83 (6th Cir. 1993), *cert denied*, 511 U.S. 1082, 114 S.Ct. 1832, 128 L.Ed. 2d 461 (1994).

Tassinare, 32 F.3d 220, 222 (6th Cir. 1994). Additionally, the *Tassinare* court continued in a footnote that:

> *Tregoning* and *Russell* both clearly explain that the agents have no right, as individual plan participants, to maintain a fiduciary claim for their personal benefit. *See Tregoning*, 12 F.3d at 83 ("the liability of a fiduciary is to reimburse the plan, not the individual participants")(citing *Russell*, 473 U.S. at 140, 105 S.Ct. at 3089).

Tassinare, 32 F.3d at 223, no. 3. Thus, despite this Court's sympathy for any harm Plaintiff may have suffered if Defendants' alleged misrepresentation did take place, the Court must follow the dictate of Sixth Circuit precedent and reject Plaintiff's attempts to recover from Defendants for breach of fiduciary duty.

Since the Court finds, as a matter of law, that Plaintiff fails to state a claim upon which relief can be granted, it will not be necessary to address the issue as to whether Plaintiff's claims are time-barred under ERISA.

III. CONCLUSION

For the foregoing reasons, the Court hereby grants Defendants' Motion for Judgment on the Pleadings/ Summary Judgment and dismisses the above-captioned matter. An Order consistent with the reasoning set forth above is filed contemporaneously.

Entered this the 10th day of June, 1997.

/s/ John T. Nixon

JOHN T. NIXON, CHIEF JUDGE
UNITED STATES DISTRICT COURT

IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF TENNESSEE NASHVILLE DIVISION

LINDA ALLINDER

v. } **No. 3-96-0272**

INTER-CITY PRODUCTS CORPORATION (USA)

MEMORANDUM

Plaintiff Linda Allinder's Motion for an Order Remanding an Action to State Court (Doc. No. 5) filed on April 17, 1996, to which Defendant Inter-City Products Corporation (USA) ("Inter-City") filed a Memorandum in Opposition (Doc. No. 7) on April 26, 1996. Also pending before this Court is Defendant's Motion for Summary Judgement (Doc. No. 8), filed on April 26, 1996 to which Plaintiff Linda Allinder has filed a Response (Doc. No. 13) on May 20, 1996.

Upon review of the record and for the reasons stated below, the Court hereby denies Plaintiff's Motion for an Order Remanding Action to State Court and grants Defendant's Motion for Summary Judgement.

I. BACKGROUND

Plaintiff Linda Allinder, a former employee of Defendant Inter-City, originally brought this matter in January of 1996 as an action in state court. Allinder charged Inter-City with refusing to complete and process forms required for Allinder to obtain insurance benefits after Allinder suffered a toxic reaction to pesticides used in her workplace. Defendant removed the case to federal court in March of 1996, on the grounds that the Plaintiff's claims were "all actions founded upon or preempted by the laws of the United States, specifically, the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001-1461. (1982).

Plaintiff next filed a Motion for an Order Remanding the Action to State Court, arguing that the action did not encompass any federal claims that would require the District Court to maintain jurisdiction. Plaintiff states that the essence of her cause of action is that the Defendant and its agents tortiously interfered with Allinder's contractual right to have her insurance claims completed and processed. Further, Plaintiff maintains that one of the Defendant's agents intentionally misrepresented the interpretation of the Plaintiff's disability policy in order to deprive Plaintiff of her benefits. Thus, Allinder argues that the case be remanded on the grounds that state law predominately governs the circumstances as alleged, since tortious interference with contractual rights, misrepresentation, and conversion are "well founded State common law causes of action."

Defendant Inter-City opposes Plaintiff's Motion to Remand and requests this Court to enter Summary Judgement on the grounds that Plaintiff's state law claims are preempted by federal law under ERISA. Defendant argues that the Plaintiff has failed to state a claim on which relief can be granted, given that all of the Plaintiff's state law claims are preempted by ERISA.

II. DISCUSSION

A. The Purpose and Scope of ERISA

ERISA is a remedial statute designed to protect the interests of employees in pension and welfare plans. *see Shaw v. Delta Airlines*, 463 U.S. 85, 103 S.Ct. 2890, 2896, 77 L.Ed.2d 490 (1983). Under ERISA §3(1), 29 U.S.C. § 1002(1), a "welfare plan" is:

> (1) a "plan, fund or program" (2) established or maintained (3) by an employer or by an employee organization, or by both, (4) for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death, unemployment or vacation benefits, apprenticeship or other training programs, day care

centers, scholarship funds, prepaid legal services or severance benefit (5) to the participants or their beneficiaries.

Donovan v. Dillinham, 688 F.2d 1367, 1371 (11th Cir., 1982). In addition to protecting employees, ERISA was also set up to protect employers from conflicting and inconsistent state and local regulation of such plans, *see Shaw*, 463 U.S. at 86, 103 S.Ct. at 2894. The former purpose is achieved through requirements for reporting, disclosure, participation rights, vesting of rights to benefits, funding fiduciary responsibilities, and claims procedures. *See* 29 U.S.C. § 1021-1145. The latter purpose is achieved through the preemption, with a few exceptions not relevant here, of all state laws relating to employee pension and welfare benefit plans. *See id.* § 1144.

Since ERISA was enacted to replace a patchwork scheme of state regulation of employee benefit plans with a uniform set of federal regulations, the preemptive clause of ERISA "is conspicuous for its breadth." *FMC Corp. v. Holliday*, 498 U.S. 52, 56-60, 111 S.Ct. 403, 406-409, 112 L.Ed.2d 356 (1990). ERISA preempts all state laws that "relate to" employee benefit plans, whether or not the state laws are designed to affect employee benefit plans. *Id.* at 58, 111 s.Ct. at 407-08. *See also* 29 U.s.C. § 1144(a). Thus, in the case at bar, it is necessary to determine if the state laws under which Plaintiff brings her claims against Inter-City "relate to" the Defendant's benefit plan covering employees' long term disabilities.

B. Plaintiff's State Law Claims are Preempted by ERISA.

Plaintiff's state law claims include tortious interference with contractual rights, intentional misrepresentation, and conversion. These claims all arise from Inter-City's refusal to accept documentation required to process Plaintiff's claim for long term disability benefits under a group long term disability plan maintained by the Defendant and funded through a group insurance policy issued by Life Insurance of North America. Plaintiff's claims against the Defendant, therefore, clearly "relate to" the benefit plan. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48,

107 S.Ct. 1549, 1553, 95 L.Ed.2d 39 (1987)("The common law causes of action [tortious breach of contract, breach of fiduciary duties, and fraud in the inducement] raised in [plaintiff's] complaint, each based on alleged improper processing of a claim for benefits under an employee benefit plan, undoubtedly meet the criteria for pre-emption....").

Plaintiff attempts to distinguish her case from *Pilot Life* by asserting that (1) Plaintiff never had the opportunity to receive disability benefits; (2) Plaintiff brings her claim against an employer rather than an insurance carrier; and (3) Defendant's actions do not constitute "improper processing of a claim for benefits," but rather a refusal to accept from Plaintiff the necessary documentation required to process her claim.

However, a plaintiff need not have had the opportunity to receive benefits in order for her claim connected with those benefits fall within the ambit of ERISA preemption. *See, e.g. Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir., 1992), *cert. denied*, 506 U.S. 1033, 113 S.Ct. 812, 121 L.Ed.2d 684 (1992) (stating that state tort claims of ERISA plan-participant who did not receive certain benefits because a utilization review organization denied the plaintiff authorization for hospitalization under the plan were preempted by ERISA).

Further, the fact that Plaintiff's claims are against her employer does not save Plaintiff's claim from preemption. *See Metropolitan Life Ins. Co. v. Taylor,* 481 U.S. 58, 62, 107 S.Ct. 1542, 1546, 95 L.Ed.2d 55 (1987) (holding that Plaintiff's state common law contract and tort claims against both employer and insurance company for decision to discontinue disability benefits were preempted by ERISA); *Moffit v. Whittle Communications L.P.*, 895 F.Supp. 961, 971-72 (E.D. Tenn., 1995) (indicating that dispute between employee and employer concerning employer's misrepresentation of disability benefits plan is governed by ERISA rather than Tennessee state law).

Finally, courts have indicated that if the actions of a non-insurer nonetheless determine the availability of benefits under an ERISA benefits plan, it can constitute "a means of processing

claims" which therefore falls within the scope of ERISA. *Tolton v. American Biodyne, Inc.*, 48 F.3d 937, 942 (6th Cir., 1995). In the case at bar, the actions of the Defendant determined the availability to the Plaintiff of her long-term disability benefits. Therefore, the Defendants' acts can be deemed to be "processing claims" for purposes of ERISA.

Thus, the Court holds that all of the Plaintiff's claims are governed by federal law as they fall within the preemptive ambit of ERISA.

III. CONCLUSION

After reviewing the record, this Court finds that each of the claims raised by the Plaintiff are preempted by ERISA and the Plaintiff has failed to state a claim on which relief could be granted. For this reason, the Court DENIES Plaintiff's Motion for an Order Remanding Action to State Court and GRANTS Defendant's Motion for Summary Judgement. The dismissal of this action is without prejudice to such rights as Plaintiff may have under ERISA.

An order consistent with these findings is filed contemporaneously.

Entered this 28th day of June, 1996.

/s/ JOHN T. NIXON

JOHN T. NIXON, CHIEF JUDGE
UNITED STATES DISTRICT
COURT